	HealthSelect	CIGNA				
		A. HMO	B. POS		C. PPO	
	In-Network	In-Network	In-Network	Out-of Network	In-Network	Out-of Network
Standard Benefit Coverage						
Deductible						
Individual	None	None	None	$300	$250	$750
Family	None	None	None	$600	$500	$1,500
Standard Coinsurance Percentage Covered by Plan		100%	100%	70% after deductible	80% after deductible	60% after deductible
Out of Pocket Maximum for specific services						
Individual		$1,000 OOP Max	$1,000 OOP Max	$3,000 OOP Max	$2,000 OOP Max	$4,000 OOP Max
Family		$2,000 OOP Max	$2,000 OOP Max	$6,000 OOP Max	$6,000 OOP Max	$12,000 OOP Max
Lifetime Maximum Benefit		Unlimited	Unlimited	$5,000,000	Unlimited	$5,000,000
Pre-existing Conditions	None	None	None	12 Months Waiting Period (18 months late entrant), waived if covered 1/01/03	12 Monts Waiting period (18 months late entrant), waived if covered 1/1/03	12 Months Waiting period (18 months late entrant), waived if covered 1/01/03
General Services						
Preventive Care	$5 Copay	$10 Copay	$15 Copay	Covered In-Network Only	$20 Copay	Covered In-Network Only
Primary Care Physician Services	$5 Copay	$10 Copay	$15 Copay	70% after deductible	$20 Copay	60% after deductible
Specialty Care Physician Services	$5 Copay	$10 Copay	$25 Copay	70% after deductible	$30 Copay	60% after deductible
Urgent Care Facility (Participating)	$5 Copay	$35 Copay	$50 Copay	70% after deductible	$50 Copay	60% after deductible
Out-patient Lab and X-Ray	No Copay	No Copay for lab or X-Ray $50 Copay for MRI & CAT	No Copay for lab or X-Ray $50 Copay for MRI & CAT	70% after deductible	80% after deductible	60% after deductible
In-patient Coverage						
Facility Charges	No Copay	No Copay	$100 Copay (reimbursed by County)	70% (Precertification Required)* after deductible	80% after deductible	60% (Precertification Required)* after deductible
Physician & Surgeon's Services	No Copay	No Copay	No Copay	70% (Precertification Required)* after deductible	80% after deductible	60% (Precertification Required)* after deductible
Outpatient Surgery	No Copay	No Copay	$50 Copay	70% (Precertification Required)* after deductible	80% after deductible	60% (Precertification Required)* after deductible
Non-certification Penalty	NA	NA	NA	$400 Penalty	$400 Penalty	$400 Penalty
Maternity						
Pre & Postnatal Exams(after pregnancy has been determined)	Copay waived after 1st visit	Copay waived after 1st visit	Copay waived after 1st visit	70% after deductible	Copay waived after 1st visit	60% after deductible
Delivery	No Copay	No Copay	$100 In-Patient Copay (reimbursed by County)	70% after deductible	80% after deductible	60% after deductible
Emergency Care (Defined by Plan)						
Emergency Room-Copay Waived @ Admit	$50 Copay	$75 Copay	$100 Copay	$100 Copay if emergency, otherwise 70%	$100 Copay	$100 Copay if emergency, otherwise 60%
Ambulance	No Copay	No Copay	No Copay	No Copay	90% after deductible	90% after deductible
Equipment & Devices						
Durable Medical Equipment	No Copay	No Copay ($3500 Max)	No Copay ($3500 Max)	Covered In-Network Only	80% after ded. ($700 max.)	60% ($700 max.)
External Prosthetics & Orthotics	No Copay	No Copay ($1000 Max)	No Copay ($1000 Max)	Covered In-Network Only	80% after $200 ded. ($1,000 max.)	60% after $200 ded, ($1000 max.)
Outpatient Rehabilitation						
Physical, Speech, and Occupational						
Therapy	$5 Copay	$10 Copay	$10 Copay	70% after deductible	$20 Copay*	60% after deductible*
Chiropractic Services Open Access; No referral required; visit limit is per calendar year	$10 Copay 12 Visits	$10 Copay 20 visits	$10 Copay 20 Visits	Covered In-Network Only	$20 Copay**	60% after deductible**
Benefit Limit per calendar year	60 Visits/Days	60 visits combined	60 visits, in-network & out-of-network combined		*60 therapy visits, in-network & out-of-network combined **Unlimited chiropractic visits	

Ancillary Benefits						
Vision & Hearing Screening	$5 Copay, $500 per year	$10 Copay	$15 Copay	Covered In-Network Only	$20 Copay	Covered In-Network Only
Other Healthcare Facilities						
Skilled Nursing Facilities						
Subscriber Payment	No Copay	No Copay	No Copay	70% after deductible	80%	60%
Limit per Contract Year	20 days per illness	90 Days Combined	90 Days Combined	90 Days Combined	90 Days Combined	90 Days Combined
Home Health Care	No Copay when medically necessary (Unlimited)	No Copay when medically necessary (Unlimited)	No Copay when medically necessary (Unlimited)	70% ded. up to 40 Days per Year	80% after deductible (Unlimited)	60% after ded. up to 40 Days per Year
Family Planning						
Sterilization						
Vasectomy	Place of Service Copay	Place of Service Copay	Place of Service Copay	70% after deductible	80% after deductible	60% after deductible
Tubal Ligation	Place of Service Copay	Place of Service Copay	Place of Service Copay	70% after deductible	80% after deductible	60% after deductible
Infertility Treatment	Not Covered	Diagnostic Services and Corrective Treatment Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only
Dependent Children						
Unmarried and legally dependant upon employee and/or spouse	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25		Covered to Age 19 Unless Full Time Student and Then Covered to Age 25	
Pharmacy Benefit	**HealthSelect**	**Walgreens Health Initiatives**	**Walgreens Health Initiatives**		**Walgreens Health Initiatives**	
	RETAIL 30-day supply	RETAIL 30-day supply	RETAIL 30-day supply		RETAIL 30-day supply	
	$5.00 Copay for Generics	Tier 1 Generics:	Tier 1 Generics:		Tier 1 Generics:	
	$15.00 Copay for Brand	25% Coinsurance; Max $10	25% Coinsurance; Max $10		25% Coinsurance; Max $10	
	MAIL ORDER 90-day supply	Tier 2 Brand (Preferred):	Tier 2 Brand (Preferred):		Tier 2 Brand (Preferred):	
	$15 Copay for Generics	30% Coinsurance; Max $25	30% Coinsurance: Max $25		30% Coinsurance; Max $25	
	$30 Copay for Brand	Tier 3 Brand (Non-Preferred):	Tier 3 Brand (Non-Preferred):		Tier 3 Brand (Non-Preferred):	
		30% Coinsurance; Max $50	30% Coinsurance; Max $50		30% Coinsurance; Max $50	
		MAIL ORDER 90-day supply	MAIL ORDER 90-day supply		MAIL ORDER 90-day supply	
		Tier 1 Generics; 20% Coinsurance; Max $28	Tier 1 Generics; 20% Coinsurance; Max $28		Tier 1 Generics; 20% Coinsurance; Max $28	
		Tier 2 Brand (Preferred); 25% Coinsurance; Max $70	Tier 2 Brand (Preferred); 25% Coinsurance; Max $70		Tier 2 Brand (Preferred); 25% Coinsurance; Max $70	
		Tier 3 Brand (Non-Preferred); 25% coinsurance; Max $140	Tier 3 Brand (Non-Preferred); 25% coinsurance; Max $140		Tier 3 Brand (Non-Preferred); 25% coinsurance; Max $140	
		Annual Out-of-Pocket Maximum	Annual Out-of-Pocket Maximum		Annual Out-of-Pocket Maximum	
		$1500 Single/$3,000 Family	$1500 Single/$3,000 Family		$1500 Single/$3,000 Family	
Behavioral Health Benefit	**United Behavioral Health**	**United Behavioral Health**	**United Behavioral Health**		**United Behavioral Health**	
Vision Benefit	**AVESIS Vision Plan**	**AVESIS Vision Plan**	**AVESIS Vision Plan**		**AVESIS Vision Plan**	
Note: Lifetime Maximum and Visits per year for Out of Network Services, cross-accumulates with In-Network.						
The plan documents under links on the Benefits Home page provide a complete description of benefits. These official documents govern if there is a discrepancy between the information on this comparison.						
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	A. HMO In-Network	B. POS In-Network	B. POS Out-of Network	C. PPO In-Network	C. PPO Out-of Network
Standard Benefit Coverage					
Deductible					
Individual	None	None	$300	$250	$750
Family	None	None	$600	$500	$1,500
Standard Coinsurance Percentage Covered by Plan	100%	100%	70% after deductible	80% after deductible	60% after deductible
Out of Pocket Maximum for specific services					
Individual	$1,000 OOP Max	$1,000 OOP Max	$3,000 OOP Max	$2,000 OOP Max	$4,000 OOP Max
Family	$2,000 OOP Max	$2,000 OOP Max	$6,000 OOP Max	$6,000 OOP Max	$12,000 OOP Max
Lifetime Maximum Benefit	Unlimited	Unlimited	$5,000,000	Unlimited	$5,000,000
Pre-existing Conditions	None	None	12 Months Waiting Period (18 months late entrant), waived if covered 1/01/03	12 Monts Waiting period (18 months late entrant), waived if covered 1/1/03	12 Months Waiting period (18 months late entrant), waived if covered 1/01/03
General Services					
Preventive Care	$10 Copay	$15 Copay	Covered In-Network Only	$20 Copay	Covered In-Network Only
Primary Care Physician Services	$10 Copay	$15 Copay	70% after deductible	$20 Copay	60% after deductible
Specialty Care Physician Services	$10 Copay	$25 Copay	70% after deductible	$30 Copay	60% after deductible
Urgent Care Facility (Participating)	$35 Copay	$50 Copay	70% after deductible	$50 Copay	60% after deductible
Out-patient Lab and X-Ray	No Copay for lab or X-Ray $50 Copay for MRI & CAT	No Copay for lab or X-Ray $50 Copay for MRI & CAT	70% after deductible	80% after deductible	60% after deductible
In-patient Coverage					
Facility Charges	No Copay	$100 Copay (reimbursed by County)	70% (Precertification Required)* after deductible	80% after deductible	60% (Precertification Required)* after deductible
Physician & Surgeon's Services	No Copay	No Copay	70% (Precertification Required)* after deductible	80% after deductible	60% (Precertification Required)* after deductible
Outpatient Surgery	No Copay	$50 Copay	70% (Precertification Required)* after deductible	80% after deductible	60% (Precertification Required)* after deductible
Non-certification Penalty	NA	NA	$400 Penalty	$400 Penalty	$400 Penalty
Maternity					
Pre & Postnatal Exams(after pregnancy has been determined)	Copay waived after 1st visit	Copay waived after 1st visit	70% after deductible	Copay waived after 1st visit	60% after deductible
Delivery	No Copay	$100 In-Patient Copay (reimbursed by County)	70% after deductible	80% after deductible	60% after deductible
Emergency Care (Defined by Plan)					
Emergency Room-Copay Waived @ Admit	$75 Copay	$100 Copay	$100 Copay if emergency, otherwise 70%	$100 Copay	$100 Copay if emergency, otherwise 60%
Ambulance	No Copay	No Copay	No Copay	90% after deductible	90% after deductible
Equipment & Devices					
Durable Medical Equipment	No Copay ($3500 Max)	No Copay ($3500 Max)	Covered In-Network Only	80% after ded. ($700 max.)	60% ($700 max.)
External Prosthetics & Orthotics	No Copay ($1000 Max)	No Copay ($1000 Max)	Covered In-Network Only	80% after $200 ded. ($1,000 max.)	60% after $200 ded, ($1000 max.)
Outpatient Rehabilitation					
Physical, Speech, and Occupational Therapy	$10 Copay	$10 Copay	70% after deductible	$20 Copay*	60% after deductible*
Chiropractic Services Open Access; No referral required; visit limit is per calendar year	$10 Copay 20 visits	$10 Copay 20 Visits	Covered In-Network Only	$20 Copay**	60% after deductible**

Benefit Limit per Contract Year	60 Visits	60 visits, in-network & out-of-network combined		*60 therapy visits, in-network & out-of-network combined	
Ancillary Benefits				** Unlimited Visits	
Vision & Hearing Screening	$10 Copay	$15 Copay	Covered In-Network Only	$20 Copay	Covered In-Network Only
Other Healthcare Facilities					
Skilled Nursing Facilities					
Subscriber Payment	No Copay	No Copay	70% after deductible	80%	60%
Limit per Contract Year	90 Days Combined	90 Days Combined	90 Days Combined	90 Days Combined	90 Days Combined
Home Health Care	No Copay when medically necessary (Unlimited)	No Copay when medically necessary (Unlimited)	70% ded. up to 40 Days per Year	80% after deductible (Unlimited)	60% after ded. up to 40 Days per Year
Family Planning					
Sterilization					
Vasectomy	Place of Service Copay	Place of Service Copay	70% after deductible	80% after deductible	60% after deductible
Tubal Ligation	Place of Service Copay	Place of Service Copay	70% after deductible	80% after deductible	60% after deductible
Infertility Treatment	Diagnostic Services and Corrective Treatment Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only
Dependent Children					
Unmarried and legally dependant upon employee and/or spouse	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)		Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)	
Pharmacy Benefit	**Walgreens Health Initiatives**	**Walgreens Health Initiatives**		**Walgreens Health Initiatives**	
	THREE LEVEL PLAN:	THREE LEVEL PLAN:		THREE LEVEL PLAN:	
	Generics:	Generics:		Generics:	
	25% Coinsurance	25% Coinsurance		25% Coinsurance	
	Min Cost $2.00, Max Cost $10.00	Min Cost $2.00, Max Cost $10.00		Min Cost $2.00, Max Cost $10.00	
	Brand On:	Brand On:		Brand On:	
	30% Coinsurance	30% Coinsurance		30% Coinsurance	
	Min Cost $5.00, Max Cost $25.00	Min Cost $5.00, Max Cost $25.00		Min Cost $5.00, Max Cost $25.00	
	Brand Off:	Brand Off:		Brand Off:	
	30% Coinsurance	30% Coinsurance		30% Coinsurance	
	Min Cost $20.00, Max Cost $50.00	Min Cost $20.00, Max Cost $50.00		Min Cost $20.00, Max Cost $50.00	
	Annual Out-of-Pocket Maximum	Annual Out-of-Pocket Maximum		Annual Out-of-Pocket Maximum	
	$1500 - Single/$3,000 Family	$1500 - Single/$3,000 Family		$1500 - Single/$3,000 Family	
Behavioral Health Benefit	**United Behavioral Health**	**United Behavioral Health**		**United Behavioral Health**	
Vision Benefit	**AVESIS Vision Plan**	**AVESIS Vision Plan**		**AVESIS Vision Plan**	

Note: Lifetime Maximum and Visits per year for Out of Network Services, cross-accumulates with In-Network.

The detailed benefit summaries provide a more comprehensive summary of benefits.

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HealthSelect

In-Network

Standard Benefit Coverage	
Deductible	
Individual	None
Family	None
Standard Coinsurance Percentage Covered by Plan	
Out of Pocket Maximum for specific services	
Individual	
Family	
Lifetime Maximum Benefit	
Pre-existing Conditions	None
General Services	
Preventive Care	$5 Copay
Primary Care Physician Services	$5 Copay
Specialty Care Physician Services	$5 Copay
Urgent Care Facility (Participating)	$5 Copay
Out-patient Lab and X-Ray	No Copay
In-patient Coverage	
Facility Charges	No Copay
Physician & Surgeon's Services	No Copay
Outpatient Surgery	No Copay
Non-certification Penalty	NA
Maternity	
Pre & Postnatal Exams(after pregnancy has been determined)	Copay waived after 1st visit
Delivery	No Copay
Emergency Care (Defined by Plan)	
Emergency Room-Copay Waived @ Admit	$50 Copay
Ambulance	No Copay
Equipment & Devices	
Durable Medical Equipment	No Copay
External Prosthetics & Orthotics	No Copay
Outpatient Rehabilitation	
Physical, Speech, and Occupational	
Therapy	$5 Copay
Chiropractic Services	
Open Access; No referral required; visit limit is per year	$10 Copay 12 Visits
Maximum Therapy & Chiropractic visits combined per	60 Visits/Days
Ancillary Benefits	
Vision & Hearing Screening	$5 Copay, $500 per year
Other Healthcare Facilities	
Skilled Nursing Facilities	
Subscriber Payment	No Copay
Limit per Contract Year	20 days per illness
Home Health Care	No Copay when medically necessary (Unlimited)
Family Planning	
Sterilization	

Vasectomy	Place of Service Copay
Tubal Ligation	Place of Service Copay
Infertility Treatment	Not Covered
Dependent Children	
Unmarried and legally dependant upon employee and/or spouse	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)
Pharmacy Benefit	**HealthSelect** RETAIL: $5.00 Copay for Generics $15.00 Copay for Brand MAIL ORDER: $15 Copay for Generics $30 Copay for Brand 90-day supply
Behavioral Health Benefit	**United Behavioral Health**
Vision Benefit	**AVESIS Vision Plan**

Note: Lifetime Maximum and Visits per year for Out of Network Services, cross-accumulates with In-Network.

The detailed benefit summaries provide a more comprehensive summary of benefits.

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